Chapter 1: Foundation of Reform

Overview

State Plan 2001: Blueprint for Change initiated the first major reform of North Carolina's mental health, developmental disabilities and substance abuse (mh/dd/sa) services system in more than thirty years. The State Plan was developed in response to the passage of Session Law 2001-437 that called for sweeping reforms in the service system over a five-year period. Carmen Hooker Odom, secretary of the North Carolina Department of Health and Human Services, initiated the State Plan to return North Carolina to its once proud level of distinction, one that includes a system of innovative and appropriate supports and services that comply with federal and state rules and expectations. This is the second annual revision.

The main concepts contained in the State Plan's original version are unchanged. Focusing the state's limited resources on those individuals who have the most severe disabilities continues as the central theme. This revision incorporates recommendations received from system stakeholders over the past two years, provides additional detail in particular areas and clarifications regarding issues that have been raised. In principle, the State Plan is a strategic process, with developments reflecting the acquisition of new knowledge and understanding.

Most people are aware of the reasons for the system reform movement in North Carolina. They agree that reform, though difficult, is necessary in order to reclaim the exemplary heritage that once characterized North Carolina's services to people with disabilities. There is some distance, however, between knowing that change must occur and moving forward to bring about reform. There may be as many perspectives and viewpoints on what the mh/dd/sa system should look like as there are people who have interest in the system. Coming together, then, becomes an important focus and challenge in finding the right road and in making the journey.

This chapter includes a review of the recent major developments in legal and social policy that indicate direction for reform. Evaluating growing trends in policy may also provide valuable hints about potential pitfalls to avoid. As public policy evolves over time, it creates the framework on which service systems are built and establishes the community context of daily life for people with disabilities. Key policy changes over recent decades, together with advances in treatment, services and supports, are reshaping the profile and design of contemporary public systems.

Changing Times

The lives of people with severe types of mental illness, emotional disturbances, developmental disabilities and substance abuse disorders have been greatly influenced by public policy. These policy developments revolve around issues such as reconciling concerns with social justice and economic efficiency, challenges present in supporting people with disabilities as full citizens and the changing perspective on relationships necessary for sustaining a quality life. Most recent

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developments at the national level and within the state of North Carolina serve to provide us with direction needed to embrace and celebrate this road that we are traveling.

Public Policy and Systems Direction

Several key issues have been at the center of the policy debates and program/service developments over recent decades. Our general struggle as a democratic society has revolved around efforts to reconcile social justice and economic concerns. Although this struggle occurs in tandem with every public policy effort, each has enjoyed a particular dominance.

Social justice was a dominant force from the mid-1950s through 1980. All three branches of the federal government worked in concert to form a new value/attitude toward people with disabilities. The civil rights and anti-poverty efforts of Congress resulted in statutes recognizing citizens suffering discrimination as well as creating financing programs for the poor such as Medicaid. The Community Mental Health Facilities Construction Act created opportunities for states to move toward community-based systems of care and programs. Simultaneously, the judicial branch strongly influenced community-based development in landmark cases citing poor conditions in many large institutional settings. Future protections from such conditions were advanced through efforts such as passage of the Civil Rights of Institutionalized Persons Act (CRIPA).

This time period also saw the advancement of due process protections against arbitrary denial of entitlements (Goldberg vs. Kelly) and increased demands for public systems to operate in the light of day (specifically, Administrative Procedures Act, Freedom of Information Act and Open Meetings Act).

Focus of the social justice era was to protect the civil rights of each individual and to establish the societal equality of people with disabilities. Two major criticisms of the time centered around whether these policies were actually working as they were intended and how to manage the spiraling expenditures of these policy efforts when public revenue strategies were in question.

These concerns ushered in a policy shift in the 1980's to deal with issues of economic efficiency – policy management and accountability. Direct fiscal changes began to occur in tax policy, revenue sharing and indexing (virtually automatic cost increases for programs), as well as indirect changes such as increasing deregulation and alternative methods to organize public policy.

Comparisons between publicly operated systems and those that are wholly privatized have shown that each has its relative merits and benefits, but neither model, taken alone, produces satisfactory results. Therefore, continuing developments in policy have focused on the best mix. These approaches clearly identify that, for the populations we serve, public entities at the state and local levels are designed to ensure public accountability, while community organizations are designed to ensure provision of services.

The concepts of social justice and economic efficiency are often posed as polar opposites. However, advancements in the disability movement would suggest that they could actually work

together. Initial responses to the adverse treatment of people with disabilities created the disability rights movement. Most of these efforts resulted in protections for what some may define as special people. However, over the past ten to twenty years we have experienced a transformation from the disability rights era to an era of full citizenship. The collective efforts of those concerned with social justice have resulted in the enactment of statutes (i.e., Americans with Disabilities Act, Individuals with Disabilities Education Act, revisions to the Rehabilitation Act, the Fair Housing Act) and court decisions (i.e., Olmstead) that have a common theme – people with disabilities are full citizens and should be afforded opportunities like all citizens.

Public Policy and Key Challenges

Much of the underlying basis for policy shifts over the last forty or fifty years stems from legal and ethical concerns about the proper role of government in the personal lives of private citizens. With regard to adults with mental illness, for example, a key policy issue has focused on deprivation of rights to due process and of personal liberty. It is a loss of freedom to impose restrictions or control on a person if that person does not have an opportunity to dispute what is being done. These fundamental freedom concerns have led to reforms in civil commitment requirements (due process considerations) and alternatives to more restrictive treatments and settings. The continued debate grapples with the relative balance between the inherent freedoms afforded each individual citizen and the restrictions or controls imposed on individuals who have mental health conditions that may inhibit their judgement in a manner that would unintentionally bring harm to themselves and/or others.

Civil liberty concerns are also the focal point of continued policy debates regarding adults with developmental disabilities; however, these issues are primarily targeted toward a desire to protect these individuals from harm. Evolving policy in this area has been strongly influenced by innovative community-based, support-oriented models of practice. As the community's ability to support and accommodate these individuals advances, the boundaries of reasonable risk expand and people with developmental disabilities are afforded new opportunities for natural community life.

As minors, children with severe emotional disturbances have limited rights and voice. Policy developments have been greatly influenced by a best interest perspective, that is, whatever is in the best interest of the child. Most recently, the best interest debate has been shaped largely by concerns regarding stabilization of life domains (family, school and friends). A child has limited and fragile life domains. Policy efforts have focused on developing a range of flexible supports that are best delivered within the life environment of the child, including adequate safeguards and alternatives where health and safety issues are a valid concern. Additionally, policy has encouraged systems collaboration as a means to create a seamless and more responsive mechanism to address child and family needs.

Sometimes, solutions to troubling policy questions begin with grassroots efforts to help oneself and others. The modern view of alcoholism arose in response to the traditional view of the alcoholic as a person of poor moral character whose treatment was relegated to city drunk tanks, wards of public hospitals or the back wards of aging and deteriorating state psychiatric hospitals. Sometimes alcoholics were sent to local jails. The birth of modern substance abuse treatment began with the creation of Alcoholics Anonymous (AA) by Bill W. and Dr. Bob in 1935. This movement was based on the premise that a recovering alcoholic could assist in the recovery of

another alcoholic through personal fellowship, support and sponsorship. This early beginning evolved into a treatment movement in the 1970's and 1980's that established a national network of professional addiction treatment services.

Research has shown that alcohol and drug abuse treatment is both clinically effective and cost effective in reducing drug consumption and also for the associated health and social consequences that characterize addiction. Treatment gains are typically found in reduced intravenous and other drug use, reduced criminality and enhanced health and productivity. Yet today, at the cultural and social policy level, there is growing evidence that, despite the proven success of treatment services, alcoholism and other addictions are being de-medicalized, re-stigmatized and re-criminalized. Care and treatment of alcoholics and addicts is once again shifting toward punishment and control in the criminal justice system. Recovering people constitute one of the largest and most invisible communities in America, and they are beginning to reassert themselves as a teaching and healing force.

Public Policy and a View of People

Policies toward people with disabilities establish the context in which they live. Over recent decades there has been a shift – moving from dependency to the notion of independence and, finally, to inter-dependence.

The dependency perspective stems from a long-held belief that the lives of people with disabilities were best placed in the hands of others who would make decisions for them for their own protection. At the height of the institutional era, more than 500,000 people were living involuntarily in these constantly impoverished institutions, dependent on government for every meal and article of clothing.

The independence perspective grew out of the civil rights movement. Renewed debate about the nature and causes of mental illness coupled with strong denunciation of long-term detention for people who had committed no crime, forced a wrenching shift in policy that had far-reaching, serious consequences. Thousands of people streamed out of state hospitals. Federal funding was available to build local clinics and to provide personal income that was intended to support community-based treatment. But several things happened that resulted in negative impact: 1) many people exercised their new found independence and failed or refused to get the help available, 2) over time funding for these programs slowly dissipated, and 3) perhaps most important, at that time the system did not know how to effectively support people with disabilities in communities.

The unsatisfactory outcomes of the independence era led to a new examination of meaningful community life. Observers began to focus on the interconnected nature of supports, services and treatment. This includes reciprocal relationships with other people, places and things and the natural human tendency to acquire resources within the interconnected world that make life safe, meaningful and satisfying. This realization paved the way to a whole new universe of possible methods and technologies that recognize and help people acquire the life supports required for living a full and rich life of choices and opportunities.

After a very rough start, the evolution of public policy over recent years coupled with advancements in knowledge, treatment, services and supports, now make it possible to develop a service system for people with disabilities that both acknowledges and honors their right to live in natural communities of their choice.

United States Reform History: 1990 – Present

During the late 1990's and early 2000's, the federal government began to place more emphasis on the quality of the nation's mental health and on mental health reform. In 1999, the first *Report of the Surgeon General on Mental Health* was released. On the 12th anniversary of the Americans with Disabilities Act, February 1, 2001, a program to promote the full participation of people with disabilities in all areas of society – the New Freedom Initiative – was announced.

The *Report of the Surgeon General on Mental Health* was the result of collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH). This collaboration and the report recognize the relationship between mental health and physical health and emphasize that mental health and mental illnesses are important concerns at all ages. The report provides a review of scientific advances in the study of mental health, indicating that mental health and physical health are inseparable. Further, "mental health" and "mental illness" are not opposite but may be considered as points on a continuum. This new research points the way toward intensifying interest and concerns about disease prevention and health promotion. Scientific literature summarized in the report also shows that a variety of effective treatments exist for various mental and behavioral disorders that may occur across a person's life span.

The report also describes how people with mental illness are stigmatized and the disparities in the availability of and access to services in comparison to other areas of health. These disparities are often connected to a person's financial status, either through inadequate mental health insurance benefits or from the lack of any health insurance. The report's premise is that negative stereotyping will dissipate when people understand mental illnesses as legitimate illnesses that are responsive to treatment.

The report makes a number of recommendations related to mental health:
- Continue to build the science base.
- Overcome stigma.
- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state-of-the-art treatments.
- Tailor treatment to age, gender, race and culture.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment.

Recognizing that there are continuing persistent obstacles for people with disabilities to realize full participation in American society, the federal New Freedom Initiative is composed of the following key components, subject to full funding by Congress:

- **Increasing access to assistive and universally designed technologies**: federal investment in assistive technology research and development and in access to assistive technology.

- **Expanding educational opportunities for Americans with disabilities**: increasing funding for the Individuals with Disabilities Education Act (IDEA) and focusing on reading in the early grades.

- **Integrating individuals with disabilities into the workforce**: expanding telecommuting, implementation of "Ticket to Work" that allows individuals with disabilities to choose their own support services and maintain health benefits when working, full enforcement of the Americans with Disabilities Act and innovative transportation planning.

- **Promoting full access to community life**: promoting home ownership through use of up to a year's Section 8 housing vouchers for down payment on a house; supporting the most integrated community-based settings for individuals with disabilities in accordance with the Olmstead Supreme Court decision; and increasing the accessibility of organizations that are currently exempt from Title III of the ADA (such as churches, mosques, synagogues and civic organizations).

The recent interest by the federal government in mental health issues and in promoting full participation by people with disabilities in the fabric of community life supports the movement for mental health reform in North Carolina.

The Center for Substance Abuse Treatment (CSAT) began the National Treatment Plan Initiative in the fall of 1998, to provide an opportunity to reach a national consensus on how best to improve substance abuse treatment. The National Treatment Plan Initiative envisions a society in which people with a history of alcohol or drug problems, people in recovery and people at risk for these problems are valued and treated with dignity and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. It envisions a society in which substance abuse and dependence are recognized as a public health issue, a treatable illness for which individuals deserve treatment. It envisions a society in which high-quality services for alcohol and drug problems are widely available and where treatment is recognized as a specialized field of expertise.

Changing the Conversation: That National Treatment Plan Initiative to Improve Substance Abuse Treatment[1] presents a set of guidelines and recommendations drawn from the work of expert panels and the many individuals across the nation that participated in public hearings and submitted comments.

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[1] Published by U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, November 2000. See www.samhsa.gov.

Advances made in developmental disabilities have centered on promoting the principles self-determination. The Community Supported Living Arrangements (CSLA) Medicaid pilot efforts of the early 1990s and the Robert Woods Johnson self-determination demonstration projects of the 1990s both led to the development of the Medicaid Independence Waiver. Public policy direction continues to build on the principles of command and control of one's life.

North Carolina Reform History: 1990 – Present

North Carolina has benefited from a history of mental health pioneers who have courageously built the mental health system we enjoy today. These people developed a much-needed focus on clients and service delivery in the communities. Their years of courageous development and advocacy cannot be dismissed.

Dorothea Dix played a large role in developing North Carolina's framework of mental institutions. When Miss Dix came to North Carolina, she discovered more than 1,000 mentally ill people housed in jails, poorhouses and private homes. She made her discovery known across the state, and eventually presented it as a "memorial" to the legislature. Her document was very compelling and emphasized that the insane should be removed from jails for the benefit of themselves and the other inmates. She pointed out the economics other states had realized through moderate employment and moderate exercise and gave details about needed buildings and equipment.

The asylum movement and community-care movement that followed were great accomplishments; yet neither was perfect. For example, the asylum movement often warehoused patients neglectfully. And, de-institutionalization of mental patients often led to abandonment on the streets or forced care by ill-prepared families and communities. Years later, some patients found themselves placed in the very jails that Dorothea Dix had deplored and emptied 100 years earlier.

Mental health reform began in earnest during the 1990s. North Carolina, like other states began an initiative to maximize federal dollars. Rapid growth in Medicaid funded services and revenues caused attention to the system. As a result of the attention, inadequacies in the administrative systems of local mh/dd/sa programs were uncovered. Due to the rapid growth, area programs had not been able to build the infrastructure quick enough to handle the Medicaid requirements. As a result, billing became problematic and intense state oversight was enacted. In addition to problems with Medicaid, in 1995 a multi-county area program went bankrupt without prior awareness of local county commissioners, although the state was aware of the situation. In 1997, another similar incident occurred when the county commissioners of a single county area mental health program had to spend $400,000 per month to keep it operational. County commissioners also began to receive increased complaints from consumers regarding local services and lack of county input. As a result the North Carolina Association of County Commissioners created a mental health task force that resulted in a recommendation to promote legislative changes in the mental health system.

At the same time that county commissioners were hearing local complaints, the Charlotte Observer ran a series of articles about problems in the mental health system, including 34 deaths at state facilities. Due to a severe nursing shortage and record keeping citations at Dorothea Dix Hospital, the federal government threatened to withhold funding. Vast differences of services and funding

existed across the state. Clearly, the lack of best practices in mental health services pointed to the need for reform.

Also during the 1990's juvenile justice reform made counties aware of the lack of system integration. State lawsuits called Thomas S and Willie M were requiring massive financial obligations by the state. The need for community services was emphasized through the Olmstead Act. Other federal changes were also occurring. The federal Medicaid agency said that states must give consumers more choice in the selection of providers. In the meantime, two additional area programs had to be dissolved for lack of funding and others experienced financial difficulties. Providers charged that area programs restricted access to public clients and public funds. Trust had eroded among all stakeholders, including the Division, area programs, providers, consumers and state facilities. Public awareness was very high regarding the problems with in the mental health system at both the state and local level. Serious changes needed to happen.

The North Carolina General Assembly contracted for a series of studies and audits of the mh/dd/sa system of services between 1995 and 1999. A state audit revealed that oversight of local programs was too removed from the both the local government structures and the state. The summary of the various studies had similar recommendations:

- Increase community capacity.
- Decrease reliance on state-operated facility services.
- Establish credible state oversight.
- Establish local accountability to local and state government.
- Examine governance options for area programs.
- Establish funding mechanisms for expanding community capacity including "bridge" funding.
- Establish consistency and standardization of services and finances across the state and among disability groups, where appropriate, for the operations of the mh/dd/sa system.

In July 2000, House Bill 1519 created the Legislative Oversight Committee (LOC) for MH/DD/SAS to develop a plan to reform the state system. Mental health reform legislation (HB 381- Session Law 2001-437) was passed in 2001. Key components of this legislation include:

(1) Consumer focused.
(2) Increased accountability to counties.
(3) Improved business practices at both the state and local level.
(4) The establishment of four governance options for the local mh/dd/sa system.
(5) The development of the local business plans through an inclusive community process that ultimately required approval by the County Commissioners.

Consumer-focused means that the system is expected to be person centered and driven – consumers get what they need, when they need it and where they are. Focus is on community-based services, supports and treatments that are outcome driven. Improved business practices means paying local programs to manage local networks of services and holding the programs accountable for achieving agreed upon outcomes. The legislation also sets a goal that each local

program must have a minimum population base of 200,000 or at least five counties to ensure scale and scope economy. Increased accountability includes a greater participation by county officials in the oversight of the local system.

State Plan 2001: Blueprint for Change was delivered to the LOC in December 2001 stating how the Department would implement reform. The first local decision required each county to select a form of governance. In October 2002 counties notified the Department which of the four governance options they had chosen. In 2003, local business plans were received from counties. Phase I local management entities (LMEs) begin operation July 2003, with Phase II and III LMEs to be certified by January 2004 and July 2004. LMEs have three years to fully implement approved local business plans.

North Carolina leaders, along with the many professional mental health associations and advocacy groups, understand the state's specialty system (mental health, developmental disabilities and substance abuse services) is once again at a crossroads. While a primary focus is still toward the people supported and served by the system, the state faces major problems due to dramatic changes in the economics of health care delivery and the unique evolutionary history of North Carolina's system of the specialty system. The massive disconnect between the resources needed for supports and services and the resources available to provide the supports and services is the most important factor facing North Carolina.

Most states face the same challenges that North Carolina does – dealing with the changes in Medicaid and Medicare. Indeed, most states are in a time of uncertainty and turmoil in the delivery of specialty supports and services. And, in many states, the changes have created disastrous results – disrupting the care of hundreds of thousands of vulnerable people. Fortunately, North Carolina has an opportunity to learn from these past experiences, avoid such disruptions and greatly improve its own system.

Mission, Principles, Vision

The mission, principles and vision of the State Plan guide and inform North Carolina's reform effort through the great changes ahead and tell us when we have achieved success. The road may be long, the journey will be hard, but the destination is in sight.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

Guiding Principles

- Treatment, services and supports to individuals and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome oriented, culturally and age appropriate, built on individual strengths, cost effective and reflect best practices.

- Research, education and prevention programs lower the prevalence of mental illness, developmental disabilities and substance abuse; reduce the impact or stigma; and lead to earlier intervention and improved treatment.

- Services should be provided in the most integrated community setting suitable to the needs and preferences of the individual and planned in partnership with the individual and/or family.

- Individuals should receive the services needed based on a person-centered plan and in consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.

- System professionals will work with individuals and their families to help them get the most from services.

- Services shall meet measurable standards of safety, quality and clinical effectiveness at all levels of the mental health, developmental disabilities and substance abuse system and shall demonstrate a dedication to excellence through adoption of a program for continuous quality improvement.

- All components of the mental health, developmental disability and substance abuse system shall operate efficiently.

Vision

- Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.

- The state's service system for persons with mental illness, developmental disabilities and substance abuse problems will have adequate, stable funding.

- System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

- All human services agencies that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

Consumers will have:
- Meaningful input into the design and planning of the service system.
- Information about services, how to access them and how to voice complaints.
- Opportunities for employment in the system.
- Easy, immediate access to appropriate services.

- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.

- Safe and humane living conditions in communities of their choice.

- Reduced involvement with the justice system.

- Services that prevent and resolve crises.

- Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life.

- Satisfaction with the quality and quantity of services.

- Access to an orderly, fair and timely system of arbitration and resolution.

Providers and managers will have:

- Opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components.

- Access to an orderly, fair and timely system of arbitration and resolution.

- Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided and that contain only those elements necessary to substantiate specific outcomes required.

- Training in services that are proven.

Managing the Challenges of Change

Since the original release of *State Plan 2001: Blueprint for Change*, the state and local communities have identified some challenges and obstacles that need to be addressed and overcome in order to take the next steps in this evolving process. It is necessary to adopt some overarching goals that guide the process to keep us on track toward the system envisioned in the State Plan.[2] The goals and direction provided in the *State Plan 2001: Blue Print for Change* as well as the *State Plan 2002* update remain relevant.

Investing for Success

There is an initial challenge for state and local systems in determining how best to manage finite resources to respond to what seems to be infinite need. To begin, we need to look very closely at whom we support and serve, as well as the manner in which we support and serve them. Consistent with the principle that government assistance is limited to those who are most in need, the target populations in the reformed system are those people with the most severe disabilities.

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[2] The goals listed here are from *Changing the Conversation*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, November 2000.

Managing Finite Resources

We are required to apply the best and emerging best practices that have resulted in positive outcomes for people. Services that fail to render real life outcomes for people need to be discontinued. Second, there should be appropriate transition plans for people with disabilities who can be served in their communities but are currently in state facilities. These people should live and receive services/supports in their communities. There is also a valid concern that some people with lower levels of need will require services from elsewhere in the community. Part of the community planning process involves looking to the community – including faith-based organizations and grassroots agencies to develop responses for all citizens in need.

No Wrong Door

There must be many avenues of access where people can enter the system and that address the need for a customer-service oriented approach with a genuine desire to help those who enter. The concept of uniform portal, described later in this document, establishes the expectation of a consistent statewide process for entering and leaving the public service system that supports and facilitates access to services no matter where the person enters.

Commit to Quality

We need to take up the challenge of continuous quality improvement. We make the best use of information available to us to help appraise our performance, measure outcomes and look constantly for opportunities to do things better. If this means breaking with a tradition that honest evaluation tells us is not effective, then we must abandon that tradition and find something that does work.

Change Attitudes

Across the board, we need to work on issues of community inclusion and capacity development for people with disabilities recognizing and honoring their right to full citizenship in communities of their choice. It means that we listen carefully to the experiences and observations of the people we serve; they have a view of the system that most of us never see. For some of us, it means loosening our grip on a present that is now the past and reaching out to embrace the promise of the future.

Building Partnerships

An important focus of this plan is the creation of opportunities for people with disabilities and their families to participate in problem solutions. People in treatment, services and recovery are the most eloquent communicators about the value of services in their own lives. We are required to recognize the unique strengths and talents that are already present throughout the system and to gather them into an integrated, synergistic whole in which each contributes its best, and the total

has greater value than the sum of any of its parts. Another essential element is to build partnerships between and among the various systems with overlapping responsibility for individuals who may have disabilities and their families. These partnerships can help all systems to fulfill their responsibilities more effectively, while assuring the best use of resources.